STATE OF MISSOURI
BUREAU OF IMMUNIZATIONS (adapted by Kilgore's Medical Pharmacy)

COVID-19 VACCINATION SCREENING AND CONSENT UNDER EMERGENCY USE AUTHORIZATION

Please complete the following information for the person receiving the COVID-19 vaccine.

PATIENT DEMOGRAPHIC INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL

DATE OF BIRTH	ARE YOU A MINOR LESS THAN 18 YRS OLD	SEX
	☐ Yes ☐ No	☐ Male ☐ Female ☐ Transgender ☐ Other

RACE	HISPANIC ETHNICITY	DO YOU HAVE A DISABILITY?
☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian/Alaskan Native ☐ None Specified ☐ Refused	☐ Yes ☐ No ☐ Unknown ☐ Refused	☐ Yes ☐ No ☐ Prefer not to answer

ADDRESS	CITY

STATE	ZIP	COUNTY	HOME PHONE	CELL PHONE

EMAIL	

☐ Private or employer insurance ☐ Underinsured ☐ Uninsured ☐ Medicare ☐ Medicaid

	HEALTH HISTORY	YES	NO	UNKNOWN
1.	Are you feeling sick today?	☐	☐	☐
2.	Have you ever received a dose of COVID-19 vaccine?	☐	☐	☐
3.	If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Janssen (J&J) ☐ Other Product Date Received _____			
4.	In the past 14 days have you had contact with a confirmed COVID-19 patient?	☐	☐	☐
5.	Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) • Polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures • Polysorbate, which is found in some vaccines, film coated tablets, and intravenous steroids • A previous dose of COVID-19 vaccine • A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction	☐	☐	☐
6.	Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐	☐
7.	Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, or any vaccine or injectable medication? This would include food, pet, venom, environmental, or oral medication allergies.	☐	☐	☐
8.	Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐	☐
9.	Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐	☐
10.	Do you have a bleeding disorder or are you taking a blood thinner?	☐	☐	☐
11.	Have you been diagnosed with an immune mediated syndrome characterized by thrombosis and thrombocytopenia or Heparin Induced Thrombocytopenia (HIT)?	☐	☐	☐
12.	Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?	☐	☐	☐
13.	Do you have dermal fillers?	☐	☐	☐
14.	Are you pregnant or breastfeeding?	☐	☐	☐
15.	Do you have or have a history of Multisystem Inflammatory Syndrome in Children or Adults (MIS-C or MIS-A)?	☐	☐	☐

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the CICP to provide benefits to certain individuals or estates of individuals who sustain a covered serious physical injury as the direct result of the administration or use of the covered countermeasures. The CICP can also provide benefits to certain survivors of individuals who die as a direct result of the administration or use the covered countermeasures identified in the PREP Act declaration. The PREP Act declaration for medical countermeasures against

COVID-19 states that the covered countermeasures are any antiviral medication, any other drug, any biologic, any diagnostic, any other device, or any vaccine used to treat, diagnose, cure, prevent, or mitigate COVID-19, the transmission of SARS-CoV-2 or a virus mutating from SARS-CoV-2, or any device used in the administration of and all components and constituent materials of any product. Information about the CICP and filing a claim is available by calling 1-855-266-2427 or visiting
https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccine
https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/moderna-covid-19-vaccine
https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/janssen-covid-19-vaccine

MINOR SELECTION OPTIONS (DOCUMENTATION REQUIRED UNLESS PARENT/GUARDIAN PRESENT)

☐ With Parent/Guardian ☐ With Parent/Guardian Consent ☐ Relative Caregiver ☐ Children's Division
☐ Married ☐ Pregnant ☐ Minor Parent ☐ Homeless Youth

PLEASE PRINT NAME of signature below

SIGNATURE OF PATIENT	RELATIONSHIP TO CLIENT	TODAY'S DATE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge and agree that I have received or have been advised of Kilgore's Medical
PRINT NAME HERE
Pharmacy's Notice of Privacy Practices and where I can obtain any revisions made to this Notice.

CLIENT SIGNATURE/LEGAL REPRESENTATIVE	RELATIONSHIP TO CLIENT	TODAY'S DATE

FOR CLINIC USE ONLY

MANUFACTURER	BRAND	LOT NUMBER
DOSE NUMBER ☐1 ☐2 ☐3	*EXP. DATE	*DATE ADMINISTERED
*EUA FACT SHEET DATE	*EUA FACT SHEET GIVEN DATE	INJECTION SITE (DELTOID) ☐L ☐R

DOCUMENTATION REQUIRED BY MINOR

☐ Yes ☐ No

☐ A minor under the care of a parent/guardian that physically appears and signs the requisite paperwork for the minor to receive the vaccination.

☐ Notarized written consent in cases where the Parent/Guardian is not present at the vaccination.

☐ Un-notarized written consent, if verbal confirmation can be obtained by telephone, in cases where the Parent/Guardian are not present at the vaccination.

☐ A minor under the care of a relative caregiver. The affidavit as explained in §431.058, RSMo, must be provided for the minor to receive the vaccination.

☐ A minor under the care of the Department of Social Services, written consent from Children's Division (or designee) or Division of Youth Services must be provided for the minor to receive the vaccination.

☐ A minor married, pregnant, or minor parent, under §431.061, RSMo (minor parent, married minor, etc.) Documentation shown at time of vaccine: _____

☐ "Homeless youth" (qualified youth) as provided in §431.056, RSMo, such documentation may be letters from persons/entities such as (but not limited to): a director or designee of a governmental or nonprofit agency that receives public or private funding to provide services to homeless persons; a location education agency liaison for homeless children and youth designated under 42 U.S.C. Section 11432(g)(1)(J)(ii); a school social worker/counselor; or a licensed attorney representing the minor in any legal matter.

Procedural note: Copies, duplications, or reproductions of certified copies of vital records are prohibited by state law. If a vital record is provded to fulfill the minor documentation requirement, review document to confirm eligibility, and then return to patient. Other minor documentation should be copied. Original versions of affidavits or written consent forms should be retained.

VACCINE DOSE

ADMINISTERED BY NAME & TITLE

AGENCY
Kilgore's Medical Pharmacy

AGENCY ADDRESS
1608 Chapel Hill Road Suite E Columbia, MO 65203

CLINIC ADMINISTRATION ADDRESS (if blank, same as agency address)